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In the Supreme Court of the United States

DEBORAH R. BAUER and DIANE G. WRIGHT, on behalf of themselves and all others similarly situated,

Petitioners,

v.

ADVANCE PCS, PCS HEALTH SYSTEMS, INC., PCS MAIL SERVICES OF FORT WORTH, INC., and PCS MAIL SERVICES OF BIRMINGHAM, INC.,

Respondents.

Petition for Writ of Certiorari to the Supreme Court of the State of Georgia

PETITION FOR WRIT OF CERTIORARI

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No.

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 2006

DEBORAH R. BAUER and DIANE G. WRIGHT, on behalf of themselves and all others similarly situated, Petitioners

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ADVANCE PCS, PCS HEALTH SYSTEMS, INC., PCS MAIL SERVICES OF FORT WORTH, INC., and PCS MAIL SERVICES OF BIRMINGHAM, INC.
Respondents

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF GEORGIA

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QUESTION PRESENTED FOR REVIEW

In this ERISA preemption case, the decision below creates an untenable predicament for health insured individuals, health care plans, and major medical insurance companies by forcing health insured individuals to sue their own health care plan or insurance companies, even though these insureds are improperly overcharged (in this case for the cancer drug tamoxifen), not by their health care plans or major medical insurance companies, but by non-ERISA entities. The Georgia Supreme Court's decision subjects major medical insurance companies and health care plans to liability even when they have properly paid benefits and correctly administered an ERISA plan. The decision below increases plan expenses and premiums; directly contradicting the congressional intent of ERISA and decisions from this Court. Respondents have overcharged breast cancer victims, such as the Petitioners, and are now attempting to use ERISA as a shield from liability. This important federalism issue transcends the facts of this case and desperately needs this Court's intervention and guidance.

The question presented is:

> Whether the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. 1001 *et seq.*, preempts state law unjust enrichment claims against a non-ERISA entity company that processes drug prescriptions, and misclassifies drugs for profit.

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PARTIES TO THE PROCEEDING

Petitioners are breast cancer patients, Bauer and Wright. They were plaintiffs in the trial court and appellees in the state court of appeals and the Supreme Court of Georgia.

Respondents are Advance PCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. (collectively "PCS"). They were defendants in the trial court and appellants in the Court of Appeals and the Supreme Court of Georgia.

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STATUTORY PROVISIONS INVOLVED

28 U.S.C. 1257(a) states in relevant part:

> Final judgments or decrees rendered by the highest court of a State in which a decision could be had, may be reviewed by the Supreme Court by writ of certiorari where the validity of a treaty or statute of the United States is drawn in question or where the validity of a statute of any State is drawn in question on the ground of its being repugnant to the Constitution, treaties, or laws of the United States, or where any title, right, privilege, or immunity is specially set up or claimed under the Constitution or the treaties or statutes of, or any commission held or authority exercised under, the United States.

29 U.S.C. 1132 states in relevant part:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought - -
>
> (1) by a participant or beneficiary - -
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

29 U.S.C. 1144 states in relevant part:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

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OPINIONS OF THE COURTS BELOW

The opinion of the Supreme Court of Georgia is reported at 632 S.E.2d 95 (Ga. S. Ct. 2006) and 280 Ga. 639 (2006). It is Appendix A in the Petition. The decision of the Georgia Court of Appeals is reported at 617 S.E.2d 637 (Ga. App. Ct. 2005) and 274 Ga. App. 381 (App. Ct. 2005). It is Appendix B to this Petition. The opinion of the United States District Court in Georgia is unpublished. It is Appendix C to this Petition. The opinion of the Georgia Superior Court is not reported. It is Appendix D to this Petition.

JURISDICTION

The judgment of the Georgia Supreme Court was entered on June 26, 2006. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATEMENT OF THE CASE

A. Factual Background

Breast Cancer victims Bauer and Wright ("Petitioners") brought a state law claim against PCS, a Pharmaceutical Benefits Manager ("PBM"), for unjust enrichment. The claim is predicated on PCS' misclassification of the generic drug, tamoxifen, as a brand name drug. This misclassification resulted in Petitioners paying higher drug co-payments for "brand name" drugs than if PCS had properly classified tamoxifen as the generic that it is. It also results in higher payments by third party payor health insurance companies and self-insured employers for the cancer drug tamoxifen. This increased cost to others ultimately results in a greater profit for PCS.

PCS functions as a cashier. PCS is not an ERISA health care plan, an ERISA entity or an ERISA fiduciary. PCS

does not determine ERISA health care plan benefits, interpret its ERISA customers' plans or make discretionary decisions of any kind regarding coverage or treatment under ERISA healthcare plans. [App. C at App. 27] PCS merely collects money. It collects money from Plan beneficiaries when they make co-payments for their drug benefits. It collects money from the plans to pay the pharmacies and/or the drug companies, and charges a fee for performing this service. PCS also acts as a mail order pharmacy, itself, with an inventory of tamoxifen purchased by cancer victims through the mail. These cancer victims buying tamoxifen from PCS through the mail pay for it at a brand price, sharing this brand cost with their 3rd party payors. [App. E at App. 39, 40]

When a person becomes a member of a health care plan that PCS services, the individual receives a notice that PCS will process drug claims for that individual. PCS' drug processing program consists of a nationwide network of pharmacies that are connected to PCS' computer system. Under this system, a patient presents a prescription along with his benefit card to a pharmacist. Before the pharmacist gives the prescription to the patient, the pharmacist accesses PCS' online computer system, through which all claims are processed, and enters the patient's identification and prescription information. PCS' database identifies the co-payment that corresponds to the patient's prescription and displays that amount on the pharmacy's computer terminal. If the PCS system indicates a co-payment is due, the pharmacist requires a patient to make the co-payment before receiving the prescription. PCS records the transaction for processing and payment by PCS to the pharmacy. PCS thereafter is paid by its customer health care plan for this service and for its advancement for the cost of drugs. PCS' mail order program operates much the same way, except PCS actually supplies the drug directly to the patient. In that respect it is a mail order pharmacy. It

maintains its own inventory of drugs such as tamoxifen. PCS bills the patient and the patient's ERISA healthcare plan for payment. PCS processes hundreds of millions of dollars of prescription claims for its clients each year. [App. E at App. 39]

Petitioners Bauer and Wright were beneficiaries of ERISA plans paid for by their former employers. Petitioners' plans expressly provided for coverage of prescription drugs. Higher co-payments were required for brand name drugs than for generic drugs. Using PCS' mail order procedure, Petitioner Bauer mailed her prescription for tamoxifen to PCS for processing. PCS processed her tamoxifen prescription as a "brand" name drug, requiring her to pay a higher co-payment. PCS' processing of this drug as brand also required Petitioner Bauer's plan to pay PCS more for "brand" tamoxifen. Similarly, when Wright purchased her tamoxifen, she also had to make a higher co-payment. [App. E at App. 44]

In this case, brand classification for Petitioners creates the ultimate price differential between the two products and impacts their co-payments. It also causes Petitioners' healthcare plans to face higher costs when paying for PCS' "brand" tamoxifen. Thus, PCS has artificially created a tamoxifen "brand" classification with the resultant increased cost to its plan customers and their breast cancer beneficiaries.

Petitioners, like many others, should not bear unnecessary expenses to receive life sustaining medication. They are only required to make generic co-payments for tamoxifen, but were charged the higher co-payment for a preferred, brand name drug - not by their ERISA plans, but by PCS. This wrongful classification is the result of PCS' company policy. PCS' wrongful classification results in breast cancer victims, nationwide, bearing responsibility for increased medication costs. [App. E at App. 44] The

wrongful classification also results in higher medication costs for the victims' healthcare plans.

Petitioners are not being denied benefits by their ERISA plans and they do not claim they are being denied benefits by their ERISA plans. They have no complaints against their ERISA plans. It is PCS which misclassifies tamoxifen as a brand name drug without regard to which ERISA plan it services or the terms of that particular ERISA plan. [App. E at App. 41-42] It is PCS against which Petitioners' claims lie.

B. Proceedings Below

On May 22, 2003, Petitioners filed this action against PCS in Superior Court of Georgia. Petitioners' amended complaint is a claim for unjust enrichment arising out of PCS' misclassification of the drug tamoxifen. [App. E] No ERISA claims were filed against PCS. No claims were filed against Petitioners' employers or insurance companies nor could such claims successfully be brought. PCS removed the case to the United States District Court for Northern District of Georgia, Atlanta Division, on the grounds that ERISA completely preempted the unjust enrichment claim. The Georgia United States District Court rejected the preemption argument, stating:

> Plaintiff does not contend that Humana denied her benefits under her health care plan. Instead, Plaintiff contends that Defendants. . . misrepresented the classification of tamoxifen, resulting in damages that are measured by the higher co-payment Plaintiff was required to pay. *The misclassification of tamoxifen was not perpetuated by any definition in Plaintiff's plan or by a decision of Humana's, but by Defendants. . . the misrepresentation affects the plan only because the plan will offer the measure of damages. These damages*

> *are sought from the Defendants, non-ERISA entities, not from the plan or Humana. Thus, the lawsuit does not affect the relationship between the principle ERISA entitles.*

[App. C at App. 29-30]

After remand, PCS moved to dismiss the action for lack of jurisdiction in the Georgia State Court. Following a string of decisions from this Court limiting the scope of ERISA's preemptive power when claims are only tangentially connected to an ERISA plan, the Georgia trial Judge denied the motion:

> The Court agrees with the assertion that Plaintiffs' healthcare plans are only incidentally relevant to this dispute.[4] As recognized by the United States Supreme Court, "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the [action] "relates to" the plan. . ." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100, 103 S. Ct. 2890, 77 L. Ed.2d 490 (1983); see also New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co. 514 U.S. 645, 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995) (noting that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.") (citations omitted). The case before the Court presents a situation where any relation between the claim and the ERISA entity is simply too remote. Recognizing a relationship between the Plaintiffs' claims and their health plans would render the 'relate to' standard virtually useless, and obviate the guidance that it currently provides.
>
> . . . .
>
> [4] The District Court ruling on the issue of super preemption recognized as much. Even though the issue

> of defensive preemption was not before that Court, Judge Camp, speaking in defensive preemption terms, recognized that 'the [Defendants' alleged] misrepresentation affects the [Plaintiffs' health] plan only because the plan will offer the measure of damages.'

[App. D at App. 33-34]

PCS appealed the trial court's decision to the Georgia Court of Appeals. Sitting *en banc*, the Georgia Court of Appeals affirmed stating:

> Although complete preemption is not the test applied once a case has been remanded to state court, we recognize that claims that are completely preempted are also expressly preempted and address this test solely to demonstrate further why *Davila* is not controlling. Four elements must be satisfied for complete preemption: there must be a relevant ERISA plan; (2) the plaintiff must have standing to sue under that plan; (3) the defendant must be an ERISA entity and (4) the complaint must seek relief like that available under ERISA § 502(a), such as a claim for benefits under a plan. The first two elements of the test are satisfied, but the third element is not because none of the PCS entities are ERISA entities. As noted above, the parties agree that PCS merely processes prescription drug claims and is not a fiduciary of either plan, unlike the defendants in *Davila*, who were both responsible for paying plan benefits and making coverage decisions. Thus, the state law claims in this action are not completely preempted as were the claims in *Davila*.
>
> . . .
>
> PCS also argues that Bauer and Wright's claims are preempted because they conflict with the civil enforcement provisions of ERISA § 502(a), 29 U.S.C § 1132(a).

> The United States Supreme Court has explained that Congress intended § 502(a) to be the exclusive remedy for rights guaranteed under ERISA. However, Bauer and Wright are not asserting rights that are guaranteed under ERISA. They do not seek to recover benefits due them under the plans. Nor do they seek to obtain relief for any breach of fiduciary duty or for any violation of any provision of ERISA or of the terms of the plans. Contrary to PCS's claims, Bauer and Wright cannot obtain the relief they seek from their ERISA plans or their employers. Thus, the relief they seek is not "within the power of the federal courts to provide."
>
> . . .
>
> Furthermore, allowing preemption of the unjust enrichment claim asserted here will not serve Congress' purpose for ERISA. As noted above, "Congress enacted ERISA to protect the interests of employees and other beneficiaries of employee benefit plans." To immunize PCS from liability for alleged improper classification of drugs for ERISA plan participants and beneficiaries, but not for persons whose benefits come from a non-ERISA source, would not promote this objective. . ."

[App. B at App. 20-21]

The Georgia Supreme Court granted certiorari, and on June 26, 2006, reversed the Georgia Court of Appeals ruling that Plaintiffs' claim was preempted under ERISA. [App. A]

REASONS FOR GRANTING THE PETITION

A. The Georgia Supreme Court's decision improperly expands ERISA pre-emption, and increases health care costs to consumers and insurance plans.

If the Georgia Supreme Court's decision stands, then PBMs such as PCS can continue to arbitrarily reclassify drugs for their own profit and thus wrongfully increase healthcare costs. If the Georgia Supreme Court's decision stands, non ERISA entities such as PBMs can hide behind ERISA preemption. Moreover, the Georgia Supreme Court's decision is in conflict with decisions from this Court and the statutory intent of ERISA.

Initially, this Court interpreted the phrase "relates to" under §514 of ERISA broadly, attributing to it a "broad common sense meaning in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Airlines, Inc.*, 436 U.S. 85, 97 (1983). Soon thereafter, this Court found the "uncritical literalism" problematic, choosing to "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995). In *Travelers*, this Court crafted a more limited view of the phrase "relates to", asserting "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for "[r]eally, universally, relations stop nowhere'". *Id.* at 656.

Disregarding this caution, the Georgia Supreme Court has broadened the preemptive power of ERISA. Petitioners' claims do not "relate to" any ERISA plan. They do not claim ERISA benefits. They do not claim a denial of benefits. They do not sue their plans' administrator or fiduciary. Their ERISA plans had zero involvement in PCS'

pricing. [App. C at App. 27 and App. E at App. 41-42] PCS does not make any decisions about health care or benefits eligibility. PCS has no involvement in the actual health care of any of the beneficiaries. Instead, PCS simply processes prescription orders and handles money. Petitioners' plans are victims of PCS as well. Petitioners' claims are clearly and simply predicated on PCS' misclassifying and overcharging cancer patients and their plans for life-saving drugs. Petitioners' claims are against a third party which unjustly benefitted from them and their plans.

In its reversal of the Georgia Court of Appeals, the Georgia Supreme Court stated that a claim would be preempted when the terms or existence of the plan is "a critical factor in establishing liability." [App. A at App. 3-4] (citing *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990). The Georgia Supreme Court was simply wrong. Plaintiffs' plans are not a "critical factor" in establishing PCS' liability. The record below clearly demonstrates that in a related case, PCS' witness, Lorraine Stevens, testified that ERISA healthcare plans have absolutely no involvement in the classification of tamoxifen or the effects of this classification on the price of tamoxifen. In a deposition she states that PCS classifies tamoxifen as brand *regardless* of the terms of any healthcare plan it services. PCS never looks at the plan before establishing the brand classification. The plan's language has nothing to do with the classification. [App. E at App. 42]

The Georgia Supreme Court also erred when it found Petitioners' claims were preempted because PCS' actions "affect[ed] the relationship between ERISA entities, namely the relative cost the ERISA beneficiaries and plans must bear for plaintiffs' tamoxifen." [App. A at App. 6]. Of course PCS affected the prices to ERISA plans and beneficiaries! It increased the cost of tamoxifen. But this remote connection is not the type of situation Congress intended the statute to preempt. Surely, a damage claim against a

company which, for example, sold stationery or computers to an ERISA plan and fraudulently inflated prices, would not be pre-empted by ERISA, yet it would "affect" the plan. Or if an evil local pharmacist fraudulently padded the bill to the plan for each prescription brought to the corner drug store by a consumer, the theft would surely not be pre-empted. But preempting all of those situations would essentially federalize every case that mentions ERISA. As this Court has held, "[a]ny state tax, or other law, that increases the cost of providing benefits to covered employees" will affect the benefit plan, "but that simply cannot mean that every state law with such an effect is pre-empted." *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). Any business dealing with ERISA plans or plan beneficiaries will have at least some remote effect on prices paid.

This Court's review is warranted to prevent non ERISA entities from unilaterally continuing to increase the costs of life saving drugs and hiding behind ERISA pre-emption. This improper conduct profoundly impacts the costs of healthcare to Americans and their healthcare plans.

B. The Georgia Supreme Court's decision undermines Congress' intent to prevent ERISA from intruding into traditional state matters.

This Court, when addressing Congress' preemption intent has "never assumed lightly that Congress has derogated state regulation, but instead [has] addressed claims of preemption with the starting presumption that Congress does not intend to supplant state law." *Travelers*, 514 U.S. 645, 655 (1995); *see also Geweke Ford v. ST. Joseph's Omni Preferred Care Inc.*, 130 F.3d 1355, 1358 (9th Cir. 1997) [stating ERISA's [l]egislative intent was not to supplant state law in fields of traditional state regula-

tion.) In *Travelers*, this Court addressed hospital surcharges regulated by states and said:

> "If the common character of rate differentials even in the absence of state action renders it unlikely that ERISA preemption was meant to bar such indirect economic influences under state law, the existence of other common state action with indirect economic effects on a plan's costs leave the intent to preempt even less likely."

A PBM's improper overcharges for a drug is "even less likely" than hospital surcharges.

Further, this Court has found the "historic police powers of the State include the regulation of matters of health and safety which the court assumes ERISA was not meant to supplant." *DeBuono* 520 U.S. at 814. (citing *Hillsborough County v. Automated Med. Labs, Inc.*, 471 U.S. 707 (1985)). "Indeed, if ERISA were concerned with any state action, such as medical-care quality standards or hospital workplace regulations that increased costs of providing certain benefits, and thereby potentially affected the choices made by ERISA plans, we would scarcely see the end of ERISA's pre-emptive reach, and the words 'relate to' would limit nothing. *California Div. of Labor Standards Enforcement v. Dillingham Const* , 519 U.S. 316, 329 (1997) (*citing Travelers*, 514 U.S. at 660-61). Also, *see* this Court's opinion in *Rush v. Moran*, 536 U.S. 355, 122 S.Ct. 2151 (2002) The Georgia Supreme Court's decision essentially precludes any claim from being filed in state court if it has even the slightest connection or relation to an ERISA claim. For sure, "[l]awsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, although obviously affected and involving ERISA plans and their trustees, are not pre-empted by ERISA §514(a)." *Mackey v. Lanier Collection Agency & Service, Inc.*, 468 U.S. 825 (1988). *Mackey* stated that

ERISA did not have enforcement mechanisms for collecting judgments; therefore state-law methods for collections should "remain undisturbed by ERISA; otherwise there would be no way to enforce such a judgment won against an ERISA plan." *Id.* at 834.

The Georgia Supreme Court below conceded that PCS is not an ERISA entity, yet erroneously found that PCS "does affect the relationship between ERISA entities." [App. A at App. 6] Wrong. *See Varity Corp. v. Howe*, 516 U.S. 489, 507-509 (1996) ("An administrator is a fiduciary under ERISA to the extent it makes discretionary decisions about whether participants are entitled to benefits under a plan's terms."); *See also Arizona State Carpenters Pension Trust v. Citibank*, 125 F.3d 715, 723 (9th Cir. 1997) ("Claims against non-fiduciaries committing wrongful acts which do not affect benefits or the administration of the plan are not preempted")

C. The Georgia Supreme Court's reliance on *Aetna* is misplaced.

In *Aetna*, *supra*, this Court barred state malpractice and negligence actions against ERISA healthcare entities for *denial of benefits*: the effect of which was to prevent increased healthcare costs. But PCS, itself, is guilty of increasing healthcare costs for its ERISA entity customers and the customers' consumer beneficiaries. The Respondents' conduct in this case increases the cost of health care by overcharging ERISA plans and their beneficiaries: blunting the practical effect of this Court's ruling in *Aetna*. Moreover, in *Aetna*, plaintiffs' complaint was that their ERISA plans denied them coverage, leading to consequential damages. Not so here. Petitioners' claims are not for benefits under the terms of their health plans. PCS is *not* Petitioners' health care plan or health care plan administrator. Petitioners would have pursued their health care

plans if those plans had anything to do with misclassifying tamoxifen as brand. But their respective plans had nothing to do with this misclassification. PCS the PBM misclassifies this cancer drug for all its customer health care plans.

The Georgia Supreme Court also misapplied the two-part test outlined in *Aetna*. *Id.* at 2458. First, the court found that Petitioners' case could have been filed under the civil enforcement provision of ERISA. Wrong. PCS is not an ERISA entity. Petitioners could not successfully sue their health care plans under ERISA's civil enforcement provisions for the deliberate conduct of PCS, which is not either Petitioners' health care plan. Petitioners' ERISA plans had no involvement in classification. [App. E at App. 41-42] Since there was not a denial of benefits in this case, plaintiffs could not have sustained a claim against their ERISA plans. The first prong is not satisfied.

The Georgia Supreme Court also held no "independent legal duty" exists in this case for PCS. Not so. PCS certainly has an independent state law legal duty to Petitioners to refrain from improperly increasing health care costs to these cancer patients and their ERISA plans. The effect of this Court's decision in *Aetna* is to keep costs of health care down. The Georgia Supreme Court's decision nullifies that effect.

ERISA was created to form a cohesive framework for claims against ERISA entities nationwide. Its goal was to create efficiency and lower costs to beneficiaries and plans while maintaining the separation of federal and state jurisdiction. *See Pilot Life Ins. Co v. Dedeaux*, 481 U.S. 41 (1987). (stating "ERISA intended to encourage the creation of such plans"). The claims against PCS in this case fall perfectly in line with the statutory intent of ERISA. The Georgia Supreme Court's decision completely undermines the intent of ERISA as well as decisions of this Court.

Conclusion and prayer

The decision of the Georgia Supreme Court conflicts with prior ERISA decisions of this Court, and expands the statute's preemptive power. This Court is respectfully requested to grant this Petition for a Writ of Certiorari to the Georgia Supreme Court to remedy the damage inflicted by its decision.

Respectfully submitted,

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APPENDIX

APPENDIX A

Supreme Court of Georgia.
ADVANCE PCS et al. v. Deborah BAUER et al.
No. S05G2011.
June 26, 2006.

SEARS, Chief Justice.

*639 We granted certiorari in this case to determine whether the Court of Appeals correctly held that the Employee Retirement Income Security Act of 1974[1] ("ERISA") did not preempt plaintiffs' claims.[2] Because plaintiffs' claims are dependent on the terms of their respective ERISA plans ("plans"), and could have been raised in the context of ERISA's civil enforcement provisions, we find that plaintiffs' claims are preempted by ERISA. Accordingly, we reverse.

*640 The plaintiffs are breast cancer survivors who were prescribed the drug tamoxifen over a period of years to reduce the chances of the cancer recurring. The defendant is Advance PCS, Inc. ("PCS"), a pharmaceutical benefits manager that contracted with plaintiffs' ERISA plan providers to process the prescription drug benefits under the plans. ERISA is a nationally uniform regulatory framework that governs operation and administration of employer-provided health insurance plans, and is "designed to promote the interests of employees and their beneficiaries in employee benefit plans."[3]

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[1] 29 U.S.C. § 1001, et seq.

[2] Advance PCS v. Bauer, 274 Ga.App. 381, 617 S.E.2d 637 (2005).

[3] Shaw v. Delta Air Lines, 463 U.S. 85, 90, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983).

Plaintiffs' ERISA plans include prescription drug benefits, which entitle plaintiffs to obtain prescribed drugs by paying a particular co-payment, and require the plan provider to cover the remaining cost of the drugs. Plaintiffs are required to pay a higher co-payment for brand name drugs than for generic drugs. Plaintiffs' claim under Georgia law that PCS was unjustly enriched by improperly classifying tamoxifen as a 'brand-name' drug, when it should have been classified as a 'generic' drug. Although the terms 'generic' and 'brand-name' are defined in plaintiffs' respective plans, PCS used independent classification sources to classify tamoxifen as a brand-name drug. Plaintiffs seek to represent themselves and persons similarly situated in a class under OCGA § 9-11-23.

Although plaintiffs' plans contain ERISA-mandated internal review procedures by which plaintiffs can appeal adverse benefit determinations, plaintiffs chose not to utilize those internal appeal procedures. Instead, plaintiffs filed a complaint seeking to represent the class of persons for whom PCS classified tamoxifen as a brand name drug "when the medical plans covering [those persons] do not permit [PCS] to classify tamoxifen as a brand name drug."

1. Express Preemption.

[1] ERISA § 514(a)[4] states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan [covered by ERISA]." "[Section] 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law . . . [and] to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal

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[4] 29 USC 1144(a).

Government."[5] The parties acknowledge that the plans are covered by ERISA, so the plaintiffs' state law claims are expressly preempted in this case if those claims "relate to" plaintiffs' ERISA plans.[6]

[2] *641 "Congress used the words 'relate to' in § 514(a) in their broad sense."[7] A cause of action 'relates to' a plan where "it has a connection with or reference to such a plan."[8] The " deliberately expansive"[9] language used in § 514(a) "indicates Congress'sintent **98 to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.' "[10]

[3][4] Where a state law tort action is "based on alleged improper processing of a claim for benefits under an employee benefit plan,"[11] that claim absolutely 'relates to' the plan.[12] A claim will also be preempted where the terms or existence of the plan is "a critical factor in

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[5] Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).

[6] Howard v. Parisian, 807 F.2d 1560, 1563 (11th Cir.1987); see also Norton v. North Ga. Foods, Inc., 211 Ga.App. 684, 686, 440 S.E.2d 263 (1994) ("state law need not be directly addressed to the pension plan to be preempted.").

[7] Shaw, 463 U.S. at 98, 103 S.Ct. 2890.

[8] Id. at 97, 103 S.Ct. 2890.

[9] Ingersoll-Rand, 498 U.S. at 138, 111 S.Ct. 478.

[10] New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995) (quoting Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981)).

[11] Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 48, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

[12] Id.; Ingersoll-Rand, 498 U.S. at 140, 111 S.Ct. 478.

establishing liability."[13]

Because the plaintiffs' claims depend entirely on the language of their plans, and whether that language entitles them to pay a generic co-payment for the drug tamoxifen, those claims are expressly preempted by ERISA. As stated in Aetna Health Inc. v. Davila, plaintiffs' claims are preempted by ERISA because any liability under those claims "derives entirely from the particular rights and obligations established by the benefits plans."[14] Plaintiffs' co-payment responsibility and entitlement exists only because the plans required plaintiffs to pay a specified amount for a generic drug and another amount for a brand name drug. Only if the plan entitles them to the generic co-payment for tamoxifen would their unjust enrichment claims against PCS have any merit.

Plaintiffs attempt to distinguish the cases finding ERISA preemption by arguing that their claims are not based on any improper denial of benefits, as there is no question that their ERISA plans entitle them to obtain tamoxifen generally. That contention, however, takes an unduly narrow view of the definition of "benefit" under an ERISA plan. It is true that plaintiffs' claims are not the typical "denial of coverage" claims that are ubiquitous in health-insurance disputes. *642 But plaintiffs' right to obtain a drug by paying a particular co-payment, which requires their plan provider to cover the remaining cost of the drug, is undeniably a plan benefit.[15]

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[13] Ingersoll-Rand, 498 U.S. at 139-140, 111 S.Ct. 478.

[14] 542 U.S. 200, 213, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

[15] See Heffner v. Blue Cross & Blue Shield of Alabama, Inc., 443 F.3d 1330, 1338 (11th Cir.2006) ("[T]he existence and amount of a plan's deductible directly affects the value of benefits offered under the plan. All other things being equal, imposing a deduct-

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Plaintiffs also argue that their claims do not "relate to" their ERISA plans because PCS's classification of tamoxifen as a brand-name drug is not based on the definitions in the plans, but is based instead on independent classification sources. PCS's reasons for classifying tamoxifen as brand-name, however, are irrelevant to plaintiffs' entitlements and any unjust enrichment by PCS based on its miscalculation of those entitlements. If plaintiffs are entitled to pay a generic co-payment for tamoxifen, based on the language and definitions of their respective plans, then plaintiffs' plan providers are obligated to provide the drug at that price regardless of any designation by PCS. If PCS's classification is deemed erroneous, and the plan providers are ordered to provide the drug as a generic drug, then any liability for the misclassification is a contractual matter between PCS and the plan providers. Whether or not PCS improperly calculated the amount plaintiffs owed for their drugs, the ultimate responsibility for such a decision, with respect to the plaintiffs, lies with the plan administrators.

[5] [6] Next, plaintiffs contend that their claims are not preempted because PCS is not an ERISA fiduciary. But the identity of the defendant is not the relevant inquiry into a preemption analysis. Rather, the question is whether plaintiffs' claims relate to an ERISA plan.[16] ERISA § 514(a) "preempts all state laws insofar as they relate to employee benefit **99 plans and is not limited to state

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[15] (...continued)
ible decreases the plan's benefits, and the value of those benefits varies inversely with the amount of the deductible. Viewed in these real economic terms, not having to pay a deductible is a benefit of a plan.").

[16] Howard, 807 F.2d at 1565.

laws as applied to plan fiduciaries."[17] "All courts of appeals to have considered the issue have held that ERISA preemption may apply regardless of whether the defendant is a plan fiduciary."[18]

In Morstein v. National Insurance Serv., Inc., the 11th Circuit held that ERISA did not preempt a state law claim brought against a non-ERISA entity, but only because that claim did "not affect relations among principal ERISA entities as such."[19] Here, the state law claim against the non-fiduciary does affect the relationship between ERISA *643 entities, namely the relative cost the ERISA beneficiaries and providers must bear for plaintiffs' tamoxifen. [20] Moreover, the claims in Morstein did not depend on the terms of any ERISA plans because there was no ERISA plan to enforce due to the alleged fraud of the defendant.[21] In this case, to the contrary, whether plaintiffs are entitled to the damages they seek depends entirely on the language of their ERISA plans.

Accordingly, plaintiffs' claims are expressly preempted by ERISA § 514(a) because the claims are entirely depend-

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[17] Id. (emphasis in original). See also Light v. Blue Cross & Blue Shield, 790 F.2d 1247, 1248-1249 (5th Cir.1986) (ERISA preempts the assertion of claims of improper benefit denials against non-fiduciary plan administrators).

[18] Corcoran v. United HealthCare Inc., 965 F.2d 1321, 1330, n. 13 (5th Cir.1992).

[19] 93 F.3d 715, 722 (11th Cir.1996).

[20] See Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 186, 188 (11th Cir.1997) ("where the state law claim brought against a non-ERISA entity affects the relationship between the ERISA entities, the state law claim is preempted.").

[21] Morstein, 93 F.3d at 717.

ent on the language and terms of the plaintiffs' ERISA plans, and thus, the claims clearly "relate to" the plans.

2. Implied Preemption.

[7] In addition, plaintiffs' claims are impliedly preempted by ERISA § 502(a)[22] because the claims could have been brought under that subsection and do not arise from any legal duty independent from plaintiffs' plans, and thus are duplicative of an action for which ERISA provides the exclusive remedy.[23]

ERISA § 502(a) provides plaintiffs with a cause of action "to recover benefits due [them] under the terms of [their] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] right to future benefits under the terms of the plan." "If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to 'enforce his rights' under the plan, or to clarify any of his rights to future benefits."[24] Here, plaintiffs could have brought an action against their plan providers under § 502(a) alleging overpayment of co-payments since the providers are obligated to provide them

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[22] 29 USC § 1132(a).

[23] Aetna Health Inc., 542 U.S. at 210, 124 S.Ct. 2488. Generally, a claim that is preempted by implication under § 502(a) will also be expressly preempted by § 514(a). New York State Conf. of Blue Cross & Blue Shield Plans, 514 U.S. at 658, 115 S.Ct. 1671 ("state laws providing alternative enforcement mechanisms also relate to ERISA plans").

[24] Aetna Health Inc., 542 U.S. at 210, 124 S.Ct. 2488.

a prescription drug benefit minus the applicable co-payment.[25]

*644 Congress intended § 502(a) to be "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits."[26] **100 "The ERISA civil enforcement mechanism is one of those provisions with such 'extraordinary pre-emptive power' that it 'converts an ordinary state common law complaint into one stating a federal claim.' "[27] Thus,

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[25] Heffner, 443 F.3d at 1338 ("[a]n action to recover overstated deductibles, to enforce a 'non deductible' provision of a plan, or to enjoin the imposition of deductibles that are not authorized by the plan is just as properly brought under ERISA § 502(a)(1)(B) as is an action to recover a benefit, to enforce a benefit provision, or to enjoin the nonpayment of benefits.").

[26] Pilot Life Ins. Co., 481 U.S. at 52, 56, 107 S.Ct. 1549 (Congressional "expectations that a federal common law of rights would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws."); see also Ingersoll-Rand, 498 U.S. at 144, 111 S.Ct. 478 (§ 502(a) provides the "exclusive remedy for rights guaranteed under ERISA.").

[27] Aetna Health Inc., 542 U.S. at 209, 124 S.Ct. 2488 (quoting Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 65-66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987)); see also Pilot Life Ins. Co., 481 U.S. at 54, 107 S.Ct. 1549 ("[T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in

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"[a]ny state-law action that duplicates, supplements, or supplants the civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted."[28]

In Aetna Health Inc.,[29] the U.S. Supreme Court ruled that a claim alleging that a plan provider failed to exercise ordinary care in the administration of plan benefits fell squarely within the scope of ERISA's cause of action under § 502(a). The Court elucidated a two-part test to determine whether a cause of action is preempted under § 502(a), stating that "[1] If an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and [2] where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely preempted." [30] Though the plaintiffs' actions in that case were brought in tort, the Court held that the duty of the provider to exercise ordinary care under Texas law did not arise independently from ERISA or the terms of the plans. [31]

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[27] (...continued)
ERISA.").

[28] Aetna Health Inc., 542 U.S. at 209, 124 S.Ct. 2488; see also Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 379, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (a state law claim that "provide[s] a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA . . . patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities.").

[29] 542 U.S. at 200, 124 S.Ct. 2488.

[30] Id. at 210, 124 S.Ct. 2488.

[31] Id. at 213, 124 S.Ct. 2488.

The two-part test from Aetna is satisfied in this case. Here, plaintiffs clearly could have appealed the drug-assessment by PCS as a benefit denial under the plans and their definitions of brand *645 and generic drugs. [32] UNDER DEPARTMENT OF laboR regulations, plan participants and beneficiaries must be permitted to appeal co-payment assessments as a partial benefit denial under the claims procedures mandated by ERISA § 502(a).[33] ACCORDINGLY, THE First aetna prong is satisfied.

Under the second prong, PCS's duty does not arise independently of the terms of the ERISA plans. The plans define generic and brand name. Although PCS admits to using independent sources to classify tamoxifen, the plaintiffs' rights are not dependent on the accuracy of PCS's sources, but on the language of their own plans. If PCS's classification sources are inconsistent with the plaintiffs' plans, the plan language would prevail and the inconsistency could have been remedied through the appeal procedures set forth in § 502(a). Plaintiffs have no unjust enrichment claim unless their plans entitle them to a generic co-payment. The plaintiffs' claim that PCS violated independent duties owed under state tort law makes no difference. As in Aetna Health Inc., the duties imposed by Georgia tort law "do not arise independently of

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[32] See e.g. Del Greco v. CVS Corp., 337 F.Supp.2d 475, 485 (S.D.N.Y.2004) (claim that defendant improperly classified tamoxifen as "brand-name drug" was a claim for benefits under ERISA § 502(a)).

[33] See U.S. Department of Labor, Frequently Asked Questions About the Benefit Claims Procedure Regulation, Question C-12, available at http://www.dol.gov/ebsa/faqs/faqs_claims_proc_reg.html, (last visited May 25, 2006).

ERISA or the plan terms."[34] If plaintiffs are not entitled to pay a generic co-payment for tamoxifen under **101 their respective plans, then PCS has not been unjustly enriched by charging them a brand-name co-payment.[35]

Accordingly, plaintiffs' claims are both expressly and impliedly preempted by ERISA.

Judgment reversed. All the Justices concur.

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[34] 542 U.S. at 212, 124 S.Ct. 2488.

[35] See also Cooperstein v. Independence Blue Cross, 2005 WL 1819972, *9 (E.D.Pa., decided August 2, 2005) (plaintiffs' claims preempted by § 502(a) because by claiming that defendants charged higher co-payment by incorrectly coding generic drugs as brand name drugs "plaintiffs essentially ask the Court to recover benefits withheld by Defendants and to enforce parts of their ERISA plan.").

APPENDIX B

Court of Appeals of Georgia.
ADVANCEPCS et al. v. BAUER, et al.
No. A05A0455.
July 13, 2005.
Certiorari Granted Nov. 18, 2005.

*381 PHIPPS, Judge.

Deborah R. Bauer & Diane G. Wright, on behalf of themselves and those similarly situated, filed a class action complaint against AdvancePCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. (collectively, PCS) for their alleged wrongful classification of the generic drug tamoxifen as a brand name drug. PCS initially removed the case to federal court based on its assertion that the action was completely preempted by the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC § 1001 et seq., as amended. Bauer and Wright filed a motion to remand the action to state court, and that motion was granted. PCS then filed a motion to dismiss the state court action for lack of subject matter jurisdiction, contending that Bauer and Wright's claims related to ERISA employee benefit plans and were therefore preempted under ERISA § 514(a), 29 USC § 1144(a). The trial court denied the motion. On appeal, PCS claims that the trial court erred in concluding that Bauer and Wright's state cause of action was not preempted by ERISA. We agree with the trial court's conclusion and affirm the denial of PCS's motion to dismiss.

Bauer and Wright are breast cancer survivors who were prescribed the drug tamoxifen to prevent the cancer from recurring. AdvancePCS and PCS Health Systems, Inc. are pharmacy benefit management companies who provide services such as processing *382 prescription drug claims

to various health insurance payors, including self-insured employers, insurance companies, health maintenance organizations and similar organizations. PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. are mail order pharmacies who, with the help of AdvancePCS and PCS Health Systems, sell prescription drugs directly to consumers whose prescription drug benefits are processed by AdvancePCS and/or PCS Health Systems.

Bauer and Wright had major medical coverage provided by their respective employers. AdvancePCS or PCS Health Systems was the pharmaceutical benefit manager for Bauer and Wright's medical coverage plans.[1] Those plans required a co-payment for prescription drugs, and the co-payment was higher for brand name drugs than for generic drugs. PCS classified tamoxifen as a brand name drug. As a result, Bauer and Wright were required to make the higher co-payment.

Bauer and Wright claimed that PCS benefitted financially from the improper classification of tamoxifen as a brand name drug and sought to require them to disgorge those economic benefits. The only theory of recovery they asserted was unjust enrichment. PCS claimed that Bauer and Wright's cause of action was preempted by ERISA and argue on appeal that the trial court erred by concluding otherwise.

ERISA regulates plans providing employees with fringe benefits. It "is a comprehensive statute designed to promote the interests of employees and their beneficiaries

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[1] The parties agree that the benefit plans are governed by ERISA.

in employee benefit plans."[2] ERISA imposes **640 certain requirements on pension and welfare plans, but does not require that employers provide any particular benefits.[3]

ERISA § 514(a), 29 USC § 1144(a), provides that, with certain exceptions not relevant here, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. "The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."[4]

Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States *383 or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries.[5]

[1] [2] [3] [4] With those purposes in mind, we consider whether Bauer and Wright's unjust enrichment cause of action "relates to" their employee benefit plans such that it would be expressly preempted by ERISA § 514(a).[6] A law "relates to" an employee benefit plan if it has a connection with or reference to such a plan, but § 514(a) is not limited to state laws specifically designed to affect employee

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[2] Shaw v. Delta Air Lines, 463 U.S., 85, 90, 103 S. Ct 2890, 77 L.Ed.2d 490 (1983) (citations omitted).

[3] See id. at 91, 103 S.Ct. 2890.

[4] ERISA § 514(c)(1), 29 USC § 1144(c)(1).

[5] Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990) (citations omitted).

[6] This "express preemption" under ERISA § 514(a), 29 USC § 1144(a), is also referred to as "defensive preemption."

benefit plans.[7] And although § 514(a) has been broadly construed, the United States Supreme Court has recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan."[8]

We do not find a sufficient connection between the state law claims asserted here and the ERISA benefit plans at issue to conclude that the claims "relate to" those plans. Bauer and Wright are not seeking, directly or indirectly, to recover benefits due them under their respective plans—they do not claim that they are entitled to any benefits from their plans that they have not received.[9] Instead, they claim that PCS misclassified the drug tamoxifen and that the erroneous classification was not based on the terms of their plans.[10]

Contrary to the dissent's argument, Bauer and Wright's unjust enrichment claims are not disguised claims for prescription drug benefits. Their claims for tamoxifen were covered by their respective plans. The plans paid for their

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[7] Shaw, supra at 96-98, 103 S.Ct. 2890.

[8] Id. at 100, n. 21, 103 S.Ct. 2890.

[9] Cf. Norton v. North Ga. Foods, 211 Ga.App. 684, 440 S.E.2d 263 (1994) (complaints sought recovery of damages for fraud and negligence for failure to pay medical benefits); Porter v. Buckeye Cellulose Corp., 189 Ga.App. 818, 819(2)(a), 377 S.E.2d 901 (1989) (appellant sought to recover disability benefits he contends were due pursuant to plan provisions).

[10] In another lawsuit, a PCS representative testified that PCS designates tamoxifen as a brand name drug for all of its clients, regardless of the language of the policy or plan applicable to a particular client. She further testified that PCS has a contract with First Data Bank, who provides information to PCS about whether a drug should be designated as generic or brand name.

portion of tamoxifen, based on PCS's classification of the drug as brand name.[11] It was PCS, not the plans or plan sponsors, who required Bauer and Wright to pay the higher *384 co-payment. And PCS's classification of tamoxifen as brand name was not based on the terms of the plans, but on information PCS received from a third party.

Further, contrary to PCS's claims, the trial court will not be required to interpret the provisions of the respective plans to address Bauer and Wright's claims. The only issue requiring reference to the plans is the price difference between the co-payment for a brand name drug and the co-payment for a generic drug. The fact that the remedy sought may affect the plan because any damages awarded to Bauer and Wright, if they ultimately prevail, will be measured based on the difference between the two co-payment **641 amounts, as set forth in the plans, is not enough for preemption.[12]

[5] In addition, Bauer and Wright have not asserted claims against their plans, their employers or any other ERISA entity. In Morstein v. Nat. Ins. Svcs.,[13] the United States Court of Appeals for the Eleventh Circuit held that "when a state law claim brought against a non-ERISA entity does not affect relations among principal ERISA entities as such, then it is not preempted by ERISA."[14] ERISA entities include the employer, the plan, the plan fiduciaries and

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[11] The plans were required to pay the higher costs associated with a brand name versus a generic drug.

[12] See Morstein v. Nat. Ins. Svcs., 93 F.3d 715, 723 (11th Cir.1996).

[13] Supra.

[14] Id. at 722.

the beneficiaries under the plan.[15] The parties agree that PCS merely processes prescription drug claims and is not a fiduciary of the plans. Thus, the principal ERISA entities in this case are Bauer and Wright, their employers and their benefit plans. We agree with the trial court's conclusion that this lawsuit does not affect the relationship between those principal ERISA entities.

PCS relies heavily on the United States Supreme Court's decision in Aetna Health v. Davila[16] to support its claim that Bauer and Wright's claims are preempted. In Davila, the plaintiffs were a participant and a beneficiary of ERISA benefit plans who sued the respective plan administrators for refusing to provide coverage for certain treatment recommended by their treating physicians. One plaintiff, Davila, was prescribed Vioxx, but the plan administrator refused to pay for it, and Davila elected to take a different medication from which he suffered a severe reaction resulting in extensive treatment and hospitalization. The other plaintiff, Calad, underwent surgery. When her plan's administrator refused to provide coverage for the extended hospital stay recommended by her physician, she was discharged. She suffered postsurgery complications that required her to return to the hospital and later claimed that the *385 complications would not have occurred if the administrator had approved her for a longer hospital stay. Davila and Calad sued separately in state court, claiming that the administrators' refusal to cover the recommended services violated their "duty to exercise ordinary care when making health care treatment decisions," and that those refusals " proximately

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[15] Id.

[16] 542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

caused" their injuries.[17]

We do not find Davila controlling for several reasons. First, Davila is factually distinguishable. Davila and Calad sued their respective plan administrators because they were denied benefits based on the terms of their ERISA plans. Bauer and Wright complain that PCS misclassified tamoxifen based on a uniform practice applied to all of its clients, relying not on the terms of any policy or plan but on information received pursuant to an agreement with a third party. Unlike the basis of liability in Davila, PCS's potential liability does not derive "entirely from the particular rights and obligations established by the benefit plans."[18]

[6] [7] Moreover, the Supreme Court in Davila was addressing the issue of complete preemption, not express preemption, to determine whether a cause of action was removable to federal court.[19] Complete preemption occurs when a federal statute wholly displaces a state law cause of action.[20] In that situation, the state law claim can be removed to federal court.[21] The Court held that the claims asserted by Davila and Calad fell within the scope of ERISA § 502(a)(1)(B), 29 USC § 1132(a)(1)(B),[22] and **642

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[17] Davila, supra, 542 U.S. 200, 124 S.Ct. 2488, 2493, 159 L.Ed.2d 312.

[18] Id. at 2498.

[19] The complete preemption issue was addressed in this case by the district court when it remanded the case to the state court.

[20] Davila, supra at 2495.

[21] Id.

[22] ERISA § 502(a)(1)(B), 29 USC § 1132(a)(1)(B), provides that a civil action may be brought by a plan participant or beneficiary "to recover benefits due to him under the terms of his plan, to

(continued...)

were therefore completely preempted by the civil enforcement provisions of ERISA § 502 and removable to federal district court.[23]

[8] [9] Although complete preemption[24] is not the test applied once a case has been remanded to state court, we recognize that claims that are completely preempted are also expressly preempted and address this test solely to demonstrate further why Davila is not controlling. Four elements must be satisfied for complete preemption: (1) there must be a relevant ERISA plan; (2) the plaintiff must have standing *386 to sue under that plan; (3) the defendant must be an ERISA entity; and (4) the complaint must seek relief like that available under ERISA § 502(a), such as a claim for benefits under a plan.[25] The first two elements of the test are satisfied, but the third element is not because none of the PCS entities are ERISA entities. As noted above, the parties agree that PCS merely processes prescription drug claims and is not a fiduciary of either plan, unlike the defendants in Davila, who were both responsible for paying plan benefits and making coverage decisions.[26] Thus, the state law claims in this

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[22] (...continued)
enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

[23] Davila, supra at 2498.

[24] The United States Court of Appeals for the Eleventh Circuit often refers to complete preemption as "superpreemption."

[25] Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1212 (11th Cir.1999).

[26] See Davila, supra at 2493.

action are not completely preempted as were the claims in Davila.[27]

[10] PCS also argues that Bauer and Wright's claims are preempted because they conflict with the civil enforcement provisions of ERISA § 502(a), 29 USC § 1132(a). The United States Supreme Court has explained that Congress intended § 502(a) to be the exclusive remedy for rights guaranteed under ERISA.[28] However, Bauer and Wright are not asserting rights that are guaranteed under ERISA. They do not seek to recover benefits due them under the plans.[29] Nor do they seek to obtain relief for any breach of fiduciary duty or for any violation of any provision of ERISA or of the terms of the plans.[30] Contrary to PCS's claims, Bauer and Wright cannot obtain the relief they seek from their ERISA plans or their employers. Thus, the relief they seek is not "within the power of the federal courts to provide."[31]

Furthermore, allowing preemption of the unjust enrichment claim asserted here will not serve Congress's purpose for ERISA. As noted above, "Congress enacted ERISA to protect the interests of employees and other beneficiaries of employee benefit plans."[32] To immunize PCS from liability for alleged improper classification of drugs for ERISA plan participants and beneficiaries, but not for

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[27] As set forth below, we would also conclude that the fourth element has not been satisfied because Bauer and Wright's complaint does not seek relief like that available under ERISA § 502(a).

[28] Ingersoll-Rand Co., supra at 144, 111 S.Ct. 478.

[29] See ERISA § 502(a)(1)(B), 29 USC § 1132(a)(1)(B).

[30] See ERISA § 502(a)(2), (3), 29 USC § 1132(a)(2), (3).

[31] Ingersoll-Rand Co., supra at 145, 111 S.Ct. 478.

[32] Morstein, supra at 723.

persons whose benefits come from a non-ERISA source, would not promote this objective.[33]

We conclude that Bauer and Wright's cause of action is not expressly preempted by ERISA § 514(a), 29 USC § 1144(a), and that it does not conflict with the civil enforcement provisions of ERISA *387 § 502(a), 29 USC § 1132(a). We therefore affirm the trial court's denial of PCS's motion to dismiss.

Judgment affirmed.

RUFFIN, C.J., and BARNES and MIKELL, JJ., concur.

ANDREWS, P.J., JOHNSON, P.J., and BLACKBURN, P.J., dissent.

ANDREWS, Presiding Judge, dissenting.

Because the claims at issue here are both expressly and impliedly preempted by ERISA, I respectfully dissent.

**643 The sole issue in this case is whether Bauer and Wright are entitled to pay the generic amount for the prescriptions provided by their medical benefit plan. That Bauer and Wright have attempted to avoid ERISA preemption of their complaint by casting it as one for "unjust enrichment" does not save it. It is the interpretation of the terms of the benefit plan at issue that determines the outcome of their claims.

As stated above, ERISA § 514(a) provides that ERISA supersedes any and all state laws as they "relate to" any employee benefit plan covered by ERISA. "Congress used the words 'relate to' in § 514(a) in their broad sense. To

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[33] See id.

interpret § 514(a) to preempt only state laws specifically designed to affect employee benefit plans would be to ignore the remainder of § 514." Shaw v. Delta Air Lines, 463 U.S. 85, 98, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983).

Federal courts "have uniformly held that state law challenges to the denial of benefits under an employee benefit plan are preempted." Howard v. Parisian, Inc., 807 F.2d 1560, 1564 (11th Cir.1987). As the majority stated, there is no dispute that the medical benefit plans are governed by ERISA. Accordingly, because Bauer and Wright's cause of action was brought to remedy only the denial of benefits under an ERISA-regulated benefit plan, it falls within the scope of and is completely preempted by ERISA § 502(a)(1)(B). Aetna Health, Inc. v. Davila, 542 U.S. 200, 124 S.Ct. 2488, 2502, 159 L.Ed.2d 312 (2004).

That the state law claim in this case seeks damages for unjust enrichment and therefore is not directly related to the benefit plan, does not demand a different result. [Where] the existence of a pension plan is a critical factor in establishing liability under the (applicable state law) . . . (the) cause of action relates not merely to pensions benefits, but to the essence of the pension plan itself. [Ingersoll-Rand Co. v. McClendon, 498 U.S. 133] at 139-140[, 111 S.Ct. 478, 483, 112 L.Ed.2d 474 (1990)]. Accordingly, state law claims have been preempted by ERISA which sought damages arising from denial of plan benefits on the basis of fraud, intentional infliction of emotional distress, breach of covenant of good faith and fair dealing, tortious interference with contract, *388 and unfair trade practices. See Howard v. Parisian, Inc., 807 F.2d 1560, 1564 (11th Cir.1987). Norton v. North Ga. Foods, 211 Ga.App. 684, 686, 440 S.E.2d 263 (1994).

The state law claims are also impliedly preempted. As previously stated, ERISA § 514(a) expressly preempts any and all state laws as they relate to any employee benefit

plan covered by ERISA. Further, even where there is no express preemption, a cause of action will be preempted if it conflicts directly with an ERISA cause of action. Ingersoll-Rand Co., supra at 142, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).

ERISA § 502(a)(1)(B) provides: "A civil action may be brought—(1) by a participant or beneficiary—. . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 USC § 1132(a)(1)(B). Under this provision, "[i]f a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to 'enforce his rights' under the plan, or to clarify any of his rights to future benefits. . .. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989)." Aetna, supra at 2496.

As appellants point out, appellees could have sought to recover any excessive co-payments under ERISA § 502(a)(1)(B) since the plan is obligated to pay them a prescription drug benefit minus the applicable co-payment. And, their entitlement to a lower generic co-payment depends entirely on their rights and obligations under the benefit plan. As stated in Aetna, when a claim is based on the denial of coverage for medical care, which logically would include prescription medication, and the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, then the suit falls within the scope of ERISA § 502(a)(1)(B). Aetna, supra at 2496. Because § 502(a) provides the exclusive remedy for enforcement of any rights or obligations created by an ERISA plan, any state law **644 cause of action that conflicts with this provision is also preempted. Ingersoll-Rand Co., supra at 142, 111 S.Ct. 478.

I find that Morstein v. Nat. Ins. Svcs., 93 F.3d 715 (11th Cir.1996), relied on by the majority, is distinguishable. In Morstein, the president and sole shareholder of a company sued an independent insurance agent and his company, claiming that he fraudulently induced her to purchase a policy of major medical insurance. Id. at 717. The court held that this claim did not fall within the scope of ERISA's preemption because it did not have sufficient connection to the plan itself to "relate to" the plan. Id. at 724. In the instant case, however, *389 benefits under the plan are the basis for the claim and the reasoning in Morstein does not apply.

The majority goes to great lengths to distinguish Aetna. First, the opinion states that the plaintiffs in Aetna were denied benefits based on the terms of their ERISA plans. I fail to see how that is different from the case before us. Second, I am puzzled as to the purpose of the majority's discussion of "complete" preemption, citing Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207 (11th Cir.1999). That case discusses "superpreemption," which concerns the existence of federal subject matter jurisdiction. Id. at 1212. As the majority acknowledges before it goes through the four elements required for complete or superpreemption, that is not applicable in this case.

Moreover, to the extent the majority contends the claims are not preempted because the defendants are not fiduciaries under the plan, that is not the law. See Howard, supra at 1564.

Also, contrary to the majority's contention, Bauer and Wright's claims are cognizable under ERISA § 502(a)(1)(B). And, as previously stated, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." Aetna, supra at 2495.

Accordingly, Bauer and Wright's claims are expressly preempted under ERISA as arising from and relating to an employee benefit plan. See ERISA § 514(a), 29 USC § 1144(a); Shaw, supra. The claims are also impliedly preempted because they conflict directly with and are duplicative of an ERISA cause of action under § 502(a). Ingersoll-Rand Co., supra at 142. Therefore, I respectfully dissent from the majority's holding to the contrary.

I am authorized to state that Presiding Judge JOHNSON and Presiding Judge BLACKBURN join in this dissent.

Ga.App.,2005.

AdvancePCS v. Bauer

APPENDIX C

United States District Court for the Northern District of Georgia, Atlanta Division

Deborah R. Bauer, Plaintiff,	)	
v.	)	
Advance PCS, PCS Health Systems, Inc., PCS Mail Services of Fort Wroth, Inc., and PCS Mail Services of Birmingham, Inc. Defendants.	)	Civil Action No. 1-03-CV-1890-JTC

ORDER dated January 21, 2004

This case is before the Court on Plaintiff's Motion to Remand [#9-1]. As this case is not pre-empted by Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"), Plaintiff's Motion to Remand [#9-1] is **GRANTED.**

I. BACKGROUND

On May 22, 2003, Plaintiff filed a class action lawsuit in the Superior Court of Fulton County, Georgia, alleging Defendants were unjustly enriched when they mis-classified the generic drug tamoxifen as a brand name drug. As a result, Plaintiff was required to pay a fifteen dollar copayment rather than ten dollar copayment under her health benefits plan. On July 7, 2003, Defendant removed this action to federal court on the basis of ERISA.

Plaintiff received medical benefits through a self-funded health benefits plan offered by her employer, Vencor Hospital ("Vencor"). Vencor contracted with Humana/PHCS ("Humana") to act as Plan Supervisor.

Thus, Humana was the plan's fiduciary and handled its administrative duties.

Humana, in turn, contracted with Defendant AdvancePCS, a pharmacy benefits management company, to handle the processing of claims for prescription drug benefits under the plan. Defendant PCS Health Systems was AdvancePCS's predecessor. Plaintiff contends that AdvancePCS would encourage participants to obtain their prescriptions from Defendants PCS Mail Services of Fort Worth and PCS Mail Services of Birmingham.

Participants in the plan would submit claims for prescription drug benefits to AdvancePCS. However, if a participant disagreed with the payment of a prescription benefit, he or she could appeal to Humana. Humana alone had the authority to approve or deny all claims, and its decisions were binding. In contrast, AdvancePCS's duties were ministerial and non-fiduciary. (Defs.' Resp. At 6 n.7.)

II. ANALYSIS

Generally, removal to federal court is proper only if a federal question appears on the face of a plaintiff's well-pleaded complaint. Engelhardt v. Paul Revere Life Ins. Co., 139 F.3d 1346, 1353 (11th Cir. 1998); Franklin v. QHG of Gadsden, Inc,. 127 F.3d 1024, 1027 (11th Cir. 1997). See also 28 U.S.C. § 1331. However, "'Congress may preempt an area of law so completely that any complaint raising claims in that area is necessarily federal in character,'" affording a basis for federal jurisdiction. Engelhardt, 139 F.3d at 1353 (quoting Kemp v. International Bus. Mach., Corp., 109 F.3d 708, 712 (11th Cir. 1997).)

In enacting ERISA, 29 U.S.C. § 1132(a), Congress created such complete preemption, called "superpreemption". Id.; Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1211 (11th Cir. 1999). Thus, even

though Plaintiff alleges only a state law claim of unjust enrichment, Defendant may remove this action if the relief Plaintiff seeks is only available under § 1132(a). Butero, 174 F.3d at 1212; Engelhardt, 139 F.3d at 1353.

ERISA superpreemption occurs in two different situations. First, if the following four elements are met, a claim is superpreempted: (1) "there must be a relevant ERISA plan;" (2) "the plaintiff must have standing to sue under that plan;" (3) "the defendant must be an ERISA entity;" and (4) the complaint must seek compensatory relief akin to that available under § 1132(a)." Butero, 174 f.3d at 1212. Second, superpreemption may also occur "when a state law claim brought against a non-ERISA entity. . .affect[s] relations among principal ERISA entities as such." Morstein, 93 F.3d at 722; Garren v. Hancock Mutual Life Ins. Co., 114 F.3d 186, 188 (11th Cir. 1997).

In this case, Defendants are not ERISA entities. "ERISA entities are the employer, the plan, the plan fiduciaries, and the beneficiaries under the plan." Morstein v. National Ins. Servs., Inc., 93 F.3d 715, 755 (11th Cir. 1996). Two of the defendants are pharmacies, and AdvancePCS admits it was not a plan fiduciary because it performed only ministerial functions. (Defs.' Resp. At 6 n.7); 29 C.F.R. § 2509.75-8; Butero, 174 F.3d at 1213 (finding Royal Macabees was an ERISA entity because the company could control the payment of benefits and the determination of the beneficiaries rights' under the plan); Morstein, 93 F.3d at 723.

Thus, the issue is whether the unjust enrichment claim against Defendants affects the relationship between Plaintiff, her plan, and Humana. Defendants contend that this lawsuit will affect the relationship between plaintiff and Humana because the Court must determine the meaning of "generic" under the plan and whether Humana properly assessed the copayment for tamoxifen as a brand drug.

The Court rejects this reasoning because AdvancePCS, not Humana, classified tamoxifen as a brand drug, and this classification was not based on definition of "generic" in Plaintiff's plan. AdvancePCS managed several plans, and, irrespective of their terms or definitions, treated tamoxifen as a brand drug across the broad.

Instead, this case is analogous to that described in Morstein. In Morstein, an independent insurance agent misrepresented the coverage in a health plan, inducing the plaintiff to purchase the plan. After a claim was rejected by the new health plan, the plaintiff sued the insurance agent for fraudulent misrepresentation. The Eleventh Circuit recognized that "[a]lthough the remedy sought may affect the plan in that Morstein's damages. . .against Hankins and/or the Shaw Agency may be measured based on what she would have received under her old plan, such indirect relation between a beneficiary and the plan is not enough for preemption." Morstein, 93 F.3d at 723.

Similarly, Plaintiff does not contend that Humana denied her benefits under her health care plan. Instead, Plaintiff contends that Defendants, like the insurance agent, misrepresented the classification of tamoxifen, resulting in damages that are measured by the higher copayment Plaintiff was required to pay. This mis-classification of tamoxifen was not perpetuated by an definition in Plaintiff's plan or by a decision of Humana's, but by Defendants. As in Morstein, the misrepresentation affects the plan only because the plan will offer the measure of damages. These damages are sought from the Defendants, non-ERISA entities, not from the plan or Humana. Thus, the lawsuit does not affect the relationship between the principal ERISA entities.

III. CONCLUSION

Plaintiff's Motion to Remand is **GRANTED**. This case is **REMANDED** to the Superior Court of Fulton County, Georgia.

SO ORDERED, This 21 day of January, 2004.

JACK T. CAMP
UNITED STATES DISTRICT JUDGE

Entered on docket
Jan. 29, 2004
By: Luther D. Thomas
Deputy clerk

APPENDIX D

Deborah Bauer and Diane G. Wright,

Plaintiffs,

v.

Advance PCS, PCS Health Systems, Inc., PCS Mail Services of Fort Wroth, Inc., and PCS Mail Services of Birmingham, Inc.

Defendants.

ORDER dated June 10, 2004

This case is before the Court on Defendants' Motion to Dismiss and on Plaintiffs' Motion for Class Certification. The court hold that Plaintiffs' claims are not preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA") Accordingly, Defendants' Motion to Dismiss is DENIED.

This Court will defer ruling on Plaintiff' Motion for Class Certification until the parties advise the Court whether or not the issue of tamoxifen being rightly or wrongly classified as brand can be resolved by a dispositive motion.

BACKGROUND

This action was originally filed in the Superior Court of Fulton County, Georgia, on May 22, 2003. On July 7, 2003, Defendants removed the action to federal court on the basis of ERISA preemption. The District Court for the Northern District of Georgia remanded the case back to the Superior Court upon finding that Plaintiff's unjust enrichment claim did not affect the relationship between Plaintiff, her plan, and Humana, and consequently that

the claim was not preempted by ERISA.

On April 30, 2004, Plaintiffs filed a Second Amended Class Action Complaint ("SAC") and Second Amended Motion for Class Certification in the Superior Court of Fulton County, Georgia, alleging that the Defendants, by misclassifying tamoxifen as a brand name drug, were unjustly enriched at the Plaintiffs' expense. The Defendants filed a Motion to Dismiss for lack of subject matter jurisdiction on the grounds that Plaintiffs' cause of action "relates to" ERISA covered employee benefit plans, and is therefore preempted by ERISA § 514(a), 29 U.S.C. § 1144(a). These motions were concurrently presented to this Court for judgment.

Plaintiffs are both breast cancer survivors who were prescribed the drug tamoxifen to prevent the recurrence of cancer. The Defendants are comprised of pharmacy benefit management companies and mail order pharmacies. The Defendants contracted with the Plaintiffs' respective health plans to manage prescription drug benefits and provide prescription drugs for health plan members. Plaintiffs' respective health plans required co-payments ("co-pays") for the purchase of prescription drugs, with a lower co-pay if the drug was generic as opposed to brand name. The Defendants classified tamoxifen as a brand name drug. Consequently, Plaintiffs were required to pay a higher co-pay amount.

In the SAC, Plaintiffs allege that Defendants deliberately misclassified tamoxifen as a brand drug in order to reap a higher profit from the drug's sales. Defendants assert that their classification of the drug is not the issue in this case. Rather, they advocate that the ultimate question raised by Plaintiffs' allegations is whether or not Plaintiffs paid the correct co-payment under the terms of their respective health plans. Defendants characterize the issue as such in order to advance their argument that

Plaintiff claims are sufficiently "related to" ERISA covered health plans so that they are preempted by ERISA § 514 (a), 29 U.S.C. § 1144(a). In the event that ERISA pre-empted the Plaintiffs' case, this court would be required to dismiss this action.

Analysis

The controlling case in this matter unambiguously states that "when a state law claim brought against a non-ERISA entity does not affect relations among principal ERISA entities as such, then it is not preempted by ERISA." Morstein v. Nat'l Ins. Sevs. Inc., 93 F.3d 715, 722 (11th Cir. 1996). The Defendants in the present case are non-ERISA entities. Further, Plaintiffs' action will not affect "relations among" their respective health plans. The Court agrees with the assertion that Plaintiffs' healthcare plans are only incidentally relevant to this dispute.[1] As recognized by the United States Supreme Court, "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the [action] 'relates to' the plan. . ." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100, 103 S. Ct. 2890, 77 L. Ed. 2d 490 (1983); see also New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995) (noting that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations

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[1] The District Court ruling on the issue of superpreemption recognized as much. Even though the issue of defensive preemption was not before that Court, Judge Camp, speaking in defensive preemption terms, recognized that "the [Defendants' alleged] misrepresentation affects the [Plaintiff's health] plan only because the plan will offer the measure of damages."

stop nowhere.") (citations omitted). The case before the Court presents a situation where any relation between the claim and the ERISA entity is simply too remote. Recognizing a relationship between the Plaintiffs' claims and their health plans would render the "relate to" standard virtually useless, and obviate the guidance that it currently provides.

Conclusion

Defendants' Motion to Dismiss is **DENIED**. The prevailing issue in this case is whether or not tamoxifen is a "generic" drug. Accordingly, the parties are ORDERED to advise the Court within 30 days whether or not this issue can be resolved by a dispositive motion. The Court defers ruling on Plaintiffs' Motion for Class Certification until the parties have complied with this order.

SO ORDERED this 10th day of June, 2004.

JUDGE JOHN J. GOGER

APPENDIX E

Fulton County Superior Court

IN THE SUPERIOR COURT OF FULTON COUNTY STATE OF GEORGIA

DEBORAH R. BAUER and DIANE G. WRIGHT, on behalf of themselves and all others similarly situated	)	
Plaintiff,	)	
v.	)	CIVIL ACTION FILE No. 2003CV70172
ADVANCE PCS, PCS HEALTH SYSTEMS, INC., PCS MAIL SERVICES OF FORT WORTH, INC., and PCS MAIL SERVICES OF BIRMINGHAM, INC.	)	
Defendant.	)	

SECOND AMENDED CLASS ACTION COMPLAINT

Plaintiffs DEBORAH R. BAUER ("BAUER") and DIANE G. WRIGHT ("WRIGHT"), on behalf of themselves and all others similarly situated, by their undersigned counsel, sue Defendants ADVANCE PCS, PCS HEALTH SYSTEMS, INC., PCS MAIL SERVICES OF FORT WORTH, INC., and PCS MAIL SERVICES OF BIRMINGHAM, INC. ("ADVANCE PCS") and allege as follows:

1.

qThis is a class action complaint brought by BAUER and WRIGHT against ADVANCE PCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc., and PCS Mail Services of Birmingham, Inc. for their wrongful classification of the generic drug tamoxifen as a brand name drug. Defendants utilized this improper classification to increase consumer co-payments and to increase their revenue at the expense of consumers. BAUER and WRIGHT seek compensatory relief for the damages they have suffered as a result of Defendants' behavior.

2.

BAUER resides in the State of Georgia living at 1746 Flagler Avenue, Atlanta, Georgia. She was an employee of Kindred Healthcare, Inc. ("Kindred") successor-in-interest to Vencor Hospital ("Vencor@) at all times relevant herein. During her employment with Kindred, she was covered for major medical benefits by the "Kindred Healthcare Inc., Medical Benefits Plan." During that period of time she was recovering from breast cancer and had been prescribed tamoxifen, a breast cancer prevention drug, by her doctor.

3.

WRIGHT resides in the State of Georgia living at 9160 Wood Green Way, Jonesboro, Georgia and was an employee of Broniec Associates Inc. ("BRONIEC") at all relevant times herein. During her employment with BRONIEC, her major medical insurance was written by Principal Life Insurance Company. During that period of time she was recovering from breast cancer and had been prescribed tamoxifen by her doctor.

4.

Advance PCS is a pharmacy benefit management company (APBM@) with its principal place of business in Irving, Texas. AdvancePCS is in the managed care business and processes prescription drug claims for insurance companies and other entities.

5.

PCS Health Systems, Inc. (APCS@) was a PBM with its principal place of business in Scottsdale, Arizona. Up until October 9, 2000, PCS was a wholly owned subsidiary of Rite Aid Corporation when it merged with Advance Paradigm, Inc. to form AdvancePCS.

6.

PCS Mail Services of Fort Worth, Inc. (APCS Mail of Fort Worth@) is a mail order pharmacy corporation with a principal place of business in Fort Worth, Texas. With the assistance of AdvancePCS and PCS, PCS Mail of Fort Worth sells prescription drugs directly to consumers participating in insurance plans whose prescription drug benefits are administered by AdvancePCS and/or PCS.

7.

PCS Mail Services of Birmingham, Inc. (APCS Mail of Birmingham@) is a mail order pharmacy corporation with a principal place of business of Birmingham, Alabama. With the assistance of AdvancePCS and PCS, PCS Mail in Birmingham sells prescription drugs directly to consumers participating in insurance plans whose prescription drug benefits are administered by AdvancePCS and/or PCS.

8.

Jurisdiction over the Defendants is proper because the Defendants have conducted business within the State of Georgia and have sufficient minimum contacts with this forum to subject them to jurisdiction. Jurisdiction and venue are proper in this Court pursuant to O.C.G.A. ' 9-10-91 and ' 9-10-93.

9.

PBMs are part of an industry that manages prescription drug benefits for insurance companies and other entities that offer prescription drug benefits to consumers. In essence, this system of prescription drug claim management is a sub-industry within the larger managed health care industry.

10.

As a matter of course and practice, PBMs enter into agreements with various health insurance payors (such as self-insured employers, unions, insurance companies, HMOs, and similar organizations) to process prescription drug claims.

11.

Beneficiaries participating in health plans offered by clients of the PBMs receive notice, that for purposes of prescription drug benefits, the beneficiary is participating in the PBMs' prescription drug processing program.

12.

As part of the Defendants managed care prescription processing program, Defendants with the help of the

various health plans, encourage all plan beneficiaries to purchase prescription drugs directly from PCS Mail of Fort Worth and PCS Mail of Birmingham. PCS Mail of Fort Worth and PCS Mail of Birmingham are hereinafter referred to as the APCS Mail Order Centers.

13.

Defendants process hundreds of millions of dollars of prescriptions drug benefits for their 1,200 clients. Defendants' associated PCS Mail Order Centers concurrently dispense over 140,000 prescriptions per month, typically in the form of three-month (90 day) supplies of medications for chronic conditions.

14.

Tamoxifen citrate is a breast cancer prevention drug manufactured by Zeneca, Inc. ("Zeneca") and sold under the brand name ANolvadex.@ The same tamoxifen citrate was distributed only by Barr Laboratories, Inc. ("Barr") in the United States as a generic drug. Barr named its generic version Atamoxifen.

15.

The processing of prescription drug claims through Defendants' computer system works in the following manner: the patient presents the prescription along with an AdvancePCS PBM card to the pharmacist. Before the pharmacist releases the prescription to the patient, the pharmacist first accesses Defendants' online computer system, through which all claims are processed, and enters the patient's identifying information and prescription information. Defendants' database electronically transfers

information regarding the patient's benefit eligibility, pricing information and co-payment amount to the pharmacy's computer terminal. If Defendants' system indicates a co-payment is due, the pharmacist requires that the patient pay the co-payment before receiving the prescription. Defendants conclude the transaction by recording it for processing and payment.

16.

If a beneficiary purchases her prescription drugs through one of the PCS Mail Order Centers, rather than a local pharmacy, the processing of the prescription drug claim works much the same way. The beneficiary completes a APCS Mail Service Order Form which is mailed to one of the PCS Mail Order Centers with an accompanying check, money order or credit card number for payment of the predetermined co-payment. After receiving the order form and appropriate co-payment, the PCS Mail Order Centers mail beneficiaries their prescriptions out of either the Fort Worth, Texas or Birmingham, Alabama processing centers.

17.

BAUER and WRIGHT were beneficiaries of medical benefits plans paid by their former employers, Kindred and BRONIEC. Under the pharmaceutical drug benefits they were to make one co-payment if a drug is generic and another co-payment if the drug is brand name. The brand name co-payment was larger than the generic co-payment.

18.

PCS' classification of tamoxifen as brand is a unilateral, arbitrary, and self-serving classification as, on July 17,

1999, in Phoenix, Arizona, the deposition of PCS DEFENDANTS' Lorraine Stevens, their most knowledgeable person with regard to tamoxifen's brand classification, occurred in the case of *Morse v. PCS, INC., et al.* case no. 99 C 0193, U. S. District Court for the Northern District of Illinois. She provided sworn testimony that PCS classifies tamoxifen as a brand-name drug *across the board* - for *all* of its insurance clients - irrespective of any individual policy variations and that *all* of the PCS - administered policies require a greater co-pay for a brand name drug. Specifically, this PCS' witness was asked the following questions and gave the following answers:[2]

* * *

"Q. So it doesn't matter which insurance company, employer, third-party administrator that PCS is administrating pharmaceutical claims for, as concerns the drug tamoxifen, PCS will also - - that will always designate it as a brand name drug, true?"

A. Correct." (pp. 7-8)

* * *

"Q. You have told us that the data base of PCS designates tamoxifen as a brand name across the board, true?

A. Correct.

Q. . . .Because PCS identifies tamoxifen as a brand name drug, it does so for every one of its clients, true?

A. True.

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[2] The entire transcript is attached as Exhibit 1.

Q. And therefore, it doesn't matter, does it, what language of any policy of any one of its clients contains insofar as PCS' designation of tamoxifen as a brand name drug, true?

A. I believe so, in the way you stated it." (Pp. 8-9)

* * *

Q. BY MR. GOLD: Now the copay for all brand name drugs, whatever the formula is for all of PCS' clients, is greater than if the drug is generic, true?

A. True.

Q. And that's true no matter who the client is, true?

A. True." (P. 10)

19.

Despite its wrongful classification as brand, tamoxifen is generic as demonstrated by the following attached authoritative exhibits demonstrating wide acceptance of its being a generic drug contrary to Defendants' classification:

A. Exhibit 2 attached, the website of drugtopics.com, showing tamoxifen is the ninth ranked *generic* drug in sales for the calendar year 1999.

B. Exhibit 3 attached, the Physicians Desk Reference illustrating that tamoxifen is a generic drug.

C. Exhibit 4 attached, the press releases from Barr Laboratories, the distributor of generic tamoxifen. (Barr Laboratories distributes its generic tamoxifen to the PCS DEFENDANTS for PCS' sale to mail order purchasers.)

D. ***Most tellingly, exhibits 5 and 6 attached, Defendants' own website pages classifying tamoxifen as generic.***

20.

As stated above, BAUER and WRIGHT suffered from breast cancer. Their oncologists had been prescribing them Barr's generic "tamoxifen" to prevent a reoccurrence of cancer.

21.

Tamoxifen citrate is a drug that interferes with the effects of the body's estrogen on breast cancer cell growth. As a treatment for breast cancer, the drug slows or stops the growth of cancer cells that are already present. Tamoxifen citrate has also been shown to help prevent the recurrence of breast cancer from returning and to prevent the development of new malignancies.

22.

Brand name Nolvadex and generic tamoxifen are functionally equivalent and require the same dosage to be effective. An analogous situation would be deciding whether to purchase a generic ibuprofen drug or to purchase the brand name Advil. Although each has the same effect on the individual's physical well-being, the brand name drug carries a greater financial cost to the beneficiary. Here, however, the difference is not only the price differential between the two products, but more importantly, the impact it has on BAUER's and WRIGHT's health insurance co-payment.

23.

In the years 2000 and 20001, BAUER filled her tamoxifen prescriptions from the PCS Mail pharmacy. WRIGHT filled her tamoxifen prescription through pharmacies from approximately 1996-2001. Defendants were pharmaceutical benefit managers for BAUER and WRIGHT's medical coverage plans during these periods.

24.

BAUER and WRIGHT's prescription expressly requested the generic drug tamoxifen (not Nolvadex). Their oncologists specifically prescribe tamoxifen because it is a generic drug.

25.

Under her plan with Kindred, Bauer should have paid a lower generic co-payment for her tamoxifen prescriptions which would have been less than her co-payment for brand Novaldex, but in September and November of 2000 and February of 2001, BAUER paid a brand name co-payment because Defendants wrongfully classify and did classify tamoxifen as a brand name drug. WRIGHT also made higher co-payments because of Defendants' wrongful classification.[3]

26.

BAUER and WRIGHT, like many others, should not have paid unwarranted fees to obtain a life sustaining prescription drug. Many consumers cannot even afford legitimate co-payments for essential prescription drugs, let alone unwarranted co-payments. BAUER and WRIGHT should

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[3] Wright's credit card statement is attached as Exhibit 7.

have only paid a generic co-payment C not a brand name co-payment.

27.

Pursuant to its internal policy, Defendants wrongfully coded tamoxifen as a brand name drug. This is true regardless of the particular consumer' s third party payor or the terms of the policy between the consumer and the consumers payor.

28.

Defendants' wrongful classification resulted in BAUER, WRIGHT, and the Class they seek to represent bearing a much higher cost.

29.

Defendants' wrongful classification of tamoxifen as a brand name drug is contrary to their stated policy of promoting the use of generic drugs.

30.

This mis-classification results in insureds paying more than they are required, thus increasing Defendants' profits and good standing with their clients.

CLASS ACTION ALLEGATIONS

31.

BAUER and WRIGHT seek to certify the following class:

All individuals who have been monetarily damaged by Defendants' mis-classification of tamoxifen as a brand name drug when the medical plans covering them do not permit Defendants to classify tamoxifen as a brand name drug.

32.

The Class is so numerous as to make joinder impracticable. The exact number of Class Members is unknown, but can be determined from records maintained by Defendants. A majority of these patients may be unaware that they have claims. Whether or not they are aware, however, their claims have damages in amounts that may be too small to justify the expense of a separate lawsuit. Aggregated, however, they make litigation financially feasible.

33.

BAUER and WRIGHT's claims are typical of the claims they seek to prosecute for the Class. BAUER and WRIGHT will fairly and adequately represent the Class and patients of the Class who are victims of the same misconduct. BAUER and WRIGHT have no interests that are antagonistic to the putative Class and BAUER and WRIGHT will vigorously pursue the claims that they assert on behalf of the Class.

34.

BAUER and WRIGHT have retained counsel who are competent and experienced in complex class action litigation and who have represented other clients in complex federal and state class action litigation. Counsel are prepared to vigorously pursue this action on behalf of BAUER, WRIGHT, and the Class.

35.

Common questions of law and fact affect the rights of each member of the Class and common relief, including injunctive relief and monetary damages, is sought for the Class.

36.

Numerous and substantial questions of law and fact, common to the Class, will control in this litigation and will predominate over any so-called individual issues.

37.

Among the common questions of law and fact with respect to the Class are the following:

a. whether Defendants wrongfully classified the generic drug tamoxifen as a brand name drug;

b. whether Defendants' conduct constitutes unjust enrichment.

38.

A class action provides a fair, efficient, and superior method, if not the only method, for adjudicating this controversy. The substantive claims are substantially the same and will require evidentiary proof of the same kind and application of a limited number of categories of law.

Claim For Relief-Unjust Enrichment

39.

As set forth above, Defendants have financially benefitted from the improper classification of Barr's generic tamoxifen as a brand-name drug.

40.

The benefit to Defendants has resulted in a direct impoverishment to Plaintiffs and the members of the class because they have paid more for Barr's generic tamoxifen than they would have been required to pay but for the misclassification.

41.

There is no justification for the enrichment of the Defendants, and it would be unjust for them to retain the benefit.

42.

There is no adequate remedy at law to require Defendants to disgorge the benefits they have enjoyed.

WHEREFORE, the Plaintiffs on behalf of themselves and all others similarly situated, demand the following relief:

a. An Order certifying this action as a class action and appointing BAUER, WRIGHT and their counsel representatives thereof;

b. Defendants' disgorgement of economic benefits in an amount to be established at trial;

c. A permanent-injunction enjoining Defendants from continuing their misclassification of tamoxifen as a brand name drug.

d. Reasonable attorneys' fees, costs and expenses incurred in connection with this suit;

e. A trial by jury on all issues so triable;

f. Pre-judgment and post-judgment interest; and

g. Such other and further relief as the Court may deem just and proper.

Respectfully submitted this___ day of_____, 2004.

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No. 06-410

IN THE

Supreme Court of the United States

DEBORAH R. BAUER AND DIANE G. WRIGHT,

Petitioners,

V.

ADVANCE PCS, PCS HEALTH SYSTEMS, INC., PCS MAIL SERVICES OF FORT WORTH, INC., AND PCS MAIL SERVICES OF BIRMINGHAM, INC.,

Respondents.

On Petition for A Writ of Certiorari to the Supreme Court of the State of Georgia

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BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the court below correctly applied to the particular facts before it the analytic framework for ERISA preemption set forth by this Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

RULE 29.6 STATEMENT

Respondents AdvancePCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. are wholly-owned subsidiaries of Caremark Rx, Inc. ("Caremark"), a publicly held corporation. No publicly held company owns 10 percent or more of Caremark's stock.

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Respondents AdvancePCS, PCS Health Systems, Inc., PCS Mail Services of Fort Worth, Inc. and PCS Mail Services of Birmingham, Inc. (collectively "PCS") respectfully request that this Court deny certiorari.

STATEMENT

A. The ERISA Plans

Through their employers, petitioners participated in employee benefit plans that included a prescription drug benefit. Pet. App. 2.[1] Under the terms of the plans, petitioners are required to make co-payments for prescription drugs. *Id.* The amount of the co-payment turns on whether the medication is a "generic" drug or a "brand name" drug. Pet. App. 2, 40. Both plans defined generic and brand name drugs for these purposes. Pet. App. 2.

PCS manages the prescription drug benefits for the plans. It has separate contracts with the plan fiduciaries to provide these administrative services. Pet. App. 1. PCS is formally designated in the plans themselves as the "administrator" or "manager" of the prescription drug benefit. (R. 1650, 1696, 1704, 1885, 1886).

The plans at issue are governed by ERISA. Accordingly, both plans contain elaborate administrative review procedures, mandated by ERISA § 503, 29 U.S.C. § 1133 (2000), for participants to appeal any adverse benefit determination by PCS. Pet. App. 2. These procedures culminate in final review by the plan fiduciaries, who have full discretionary authority to interpret their respective plan's terms.

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[1] Although the two plans at issue contain minor differences in wording, their essential features are the same.

B. The Procedural History

In processing petitioners' prescription drug benefit claims, PCS treated the drug tamoxifen as a brand name, rather than a generic drug for purposes of the plans' co-payment provisions. Rather than challenging this benefit determination in the plans' ERISA-maintained internal review procedures, petitioners by-passed them entirely and instead filed a state tort action for unjust enrichment against PCS. Pet. App. 2. The gravamen of the complaint was that PCS had misapplied the terms of the plans in assessing the higher co-payment applicable to name brand drugs under the plans. Indeed, this was clear from the face of the complaint where they sought class certification to represent:

> All individuals who have been monetarily damaged by Defendants' mis-classification of tamoxifen as a brand named drug *when the medical plans covering them do not permit Defendants to classify tamoxifen as a brand name drug.*

Pet. App. 46 (emphasis added).

PCS removed the action to federal court, asserting that that the state law claim was "completely" preempted because it falls within the scope of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (2000). That provision affords plan participants and beneficiaries a cause of action to obtain benefits or enforce rights under an ERISA plan. PSC argued that the state-law claim here was an attempt to enforce rights under the ERISA plan, because PCS's liability is dependent upon a showing that the plan participants are entitled to a generic co-payment for tamoxifen. The district court disagreed, believing that the analysis for complete preemption turned on whether the defendant is an ERISA fiduciary. Pet. App. 28-30. It remanded the case to the state court. Pet. App. 30.

On remand, PCS moved to dismiss the state court action under ERISA's express preemption provision, ERISA § 514(a), 29 U.S.C. § 1144(a) (2000). That provision states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. *Id.* The state trial court denied the motion to dismiss, but certified the order for immediate appeal. Pet. App. 31-34.

Thereafter, this Court issued *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). In *Aetna*, plan participants brought state law claims against HMOs for refusing to provide certain medical services under the ERISA plans. *Id.* at 205. The HMOs had separate contracts with the ERISA plan sponsors to administer the plans. *Id.* This Court announced that a state law action is completely preempted when: (1) the plaintiff could have originally brought her cause of action under ERISA's civil enforcement provisions and (2) no legal duty independent of ERISA or the plan's terms is violated by defendant. *Id.* at 210. In light of *Aetna*, PCS argued in the appellate court that Petitioners' state law claims were both expressly preempted by ERISA § 514(a) and impliedly preempted by the cause of action for plan benefits set forth in ERISA § 502(a)(1)(B).

The seven-member Georgia Court of Appeals was sharply divided over the application of *Aetna*'s two-part test to these facts. The majority found that the *Aetna* criteria was not satisfied and that the state law claim was not preempted by ERISA. Pet. App. 12-21.[2] Three judges dissented, noting

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[2] The majority also relied heavily upon *Morstein v. National Insurance Services, Inc.*, 93 F.3d 715 (11th Cir. 1996). That case involved a state law action against an insurance agent and agency for fraudulently representing that a replacement policy would provide the same coverage as the

(Continued ...)

that the "majority goes to great lengths to distinguish *Aetna*." Pet. App. 24. The dissent felt that *Aetna* was the controlling precedent because, in both *Aetna* and the case at bar, the plaintiffs were denied benefits based on the terms of their ERISA plans. Pet. App. 24.

C. The Supreme Court of Georgia's Decision

A unanimous Supreme Court of Georgia reversed. Pet. App. 1-30. Applying the analytical framework announced in *Aetna*, the court below found that petitioners' state law claim was preempted "[b]ecause plaintiffs' claims are dependent on the terms of their respective ERISA plans ..., and could have been raised in the context of ERISA's civil enforcement provisions." Pet. App. 1. The Supreme Court of Georgia relied upon ERISA §§ 514(a) and 502(a).

ERISA § 514(a). First, the court found that petitioners' state law claim "relates to" the plans at issue and therefore is expressly preempted by ERISA. Pet. App. 3-7. The court reasoned that the state law claim "depend[s] entirely on the language of their plans" and "whether that language entitled them to pay a generic co-payment for Tamoxifen." Pet. App. 4. As the court explained, PCS's liability is derived entirely from rights and obligations established by the plans:

> Plaintiffs' co-payment responsibility and entitlement exists only because the plans required plaintiffs to pay a specified amount for a generic drug and another amount for a brand name drug. Only if the plan entitles them to a generic co-

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existing policy for pre-existing conditions when, in fact, the replacement policy did not provide such coverage. *Id.* at 716-17. The Eleventh Circuit found that the state law claims were not preempted.

> payment for tamoxifen would their unjust enrichment claims against PCS have any merit.

Pet. App. 4.

The court rejected petitioners' attempt to distinguish this Court's precedent finding ERISA preemption. For example, petitioners argued that their claim is "not based on any improper denial of benefits." Pet. App. 4. The Supreme Court of Georgia disagreed: "plaintiffs' right to obtain a drug by paying a particular co-payment, which requires their plan provider to cover the remaining cost of the drug, is undeniably a plan benefit." *Id.*

The court below found "irrelevant" that PCS's classification of tamoxifen was not based on definitions in the plans. Pet. App. 5. The court explained that the "ultimate responsibility" for PCS's classification decisions "lies with the plan administrators." *Id.* If petitioners are entitled to the lower co-payment, then the "plan providers are obligated to provide the drug at that price regardless of any designation by PCS" and "any liability for the misclassification will be a contractual matter between PCS and the plan providers." *Id.*

The court also found irrelevant that PCS is not an ERISA fiduciary. Pet. App. 5. "'All courts of appeals to have considered the issue have held that ERISA preemption may apply regardless of whether the defendant is a plan fiduciary.'" *Id.* (*quoting Corcoran v. United HealthCare Inc.*, 965 F.2d 1321, 1330 n.13 (5th Cir. 1992)).

ERISA § 502(a). The state high court independently found implied preemption under ERISA § 502(a)(1)(B). Pet. App. 7-11. The court reasoned that the "two-part test from *Aetna* is satisfied in this case." Pet. App. 10. As for the first prong, the court found that petitioners "clearly" could have appealed the drug classification by PCS as a benefits denial under the plans and could have brought their claim under

Section 502(a) of ERISA seeking to enforce their rights under their plans. *Id.* As the court noted, the Department of Labor has indicated that plan participants "must be permitted to appeal co-payment assessments as a partial benefit denial under the claims procedures mandated by ERISA § 502(a)." *Id.* As for the second prong of *Aetna*, the court below found that the claim did not arise from any legal duty independent from the terms of their ERISA plans and thus the action was duplicative of an action for which ERISA provides the exclusive remedy. Pet. App. 10-11. "Plaintiffs have no unjust enrichment claim unless their plans entitle them to a generic co-payment." Pet. App. 10.

REASONS WHY THE PETITION SHOULD BE DENIED

The opinion of the Supreme Court of Georgia was unanimous. It was in complete accord with this Court's most recent decision on ERISA preemption in *Aetna* and plainly does not conflict with that or any of the Court's earlier preemption decisions. Nor does the decision below conflict with any decision of a federal court of appeals or another state court of last resort. Review by this Court is not warranted.

I. The Court Below Correctly Applied This Court's Recent Decision In *Aetna*

Petitioners argue (Pet. 14) that the Supreme Court of Georgia "misapplied the two-part test outlined in *Aetna*." An alleged misapplication of a correct legal standard to a particular case, however, does not ordinarily merit review by this Court. *See* Sup. Ct. R. 10 ("A petition for a writ of certiorari is rarely granted when the asserted error consists of * * * the misapplication of a properly stated rule of law."). Instead, "[a] petition for writ of certiorari will be granted only for compelling reasons" such as to resolve conflicting

decisions among state high courts or federal appellate courts on an important federal question. Sup. Ct. Rule 10(a). Here, petitioners have not alleged that the Supreme Court of Georgia applied *Aetna* in a way that conflicts with any lower court. Review is not warranted.

In any event, the court below correctly applied *Aetna*. Petitioners argue (Pet. 14) that the first prong in *Aetna* is not satisfied because they "could not successfully sue their health care plans under ERISA's civil enforcement provisions for the deliberate misconduct of PCS ...." As the court below noted, the Department of Labor requires that plan participants and beneficiaries be permitted to appeal any co-payment assessment as a partial benefit denial under the claims procedure mandated by ERISA § 502(a). Pet. App. 10. In *Del Greco v. CVS Corp.*, 337 F. Supp. 2d 475 (S.D.N.Y. 2004), *aff'd*, 164 Fed. Appx. 75 (2d Cir. 2006), a beneficiary sued the plan administrator under ERISA § 502(a), claiming that she was wrongfully required to pay a "brand name" rather than a "generic" co-payment when she purchased tamoxifen citrate. The district court found that Tamoxifen was properly classified as a "branded" drug for co-payment purposes under the terms of the health plans at issue, and therefore granted summary judgment in favor of the plan administrator. *Id.* at 491-98.[3] Petitioners need not have a "successful" claim under ERISA § 502(a) for preemption to apply, and they cannot use a state cause of

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[3] The same *Del Greco* plaintiff also brought a related ERISA action asserting similar claims against another defendant (Medco Health Solutions). The district court dismissed those claims too. *See Del Greco v. CVS Corp.*, 354 F. Supp. 2d 381, 386-87 (S.D.N.Y. 2005), *aff'd*, 164 Fed. Appx. 75 (2d Cir. 2006).

action to avoid the applicable standard of review in ERISA cases.[4]

As the court below further found, the second prong of *Aetna* is satisfied here because plaintiffs' claims do not arise independently of ERISA or the plan terms. Pet. App. 10-11. But for its obligation to process claims for prescription drug benefits under the Plans, PCS would have no relationship with petitioners. The plans at issue in this case not only direct participants to submit claims for prescription drug benefits to PCS, but also specifically define "generic" drug for purposes of determining applicable co-payments. As the court below found, petitioners "have no unjust enrichment claim unless their plans entitle them to a generic co-payment." Pet. App. 10.

A federal district court found complete preemption under ERISA § 502(a) on similar facts. *See Cooperstein v. Independence Blue Cross,* 36 Employee Benefits Cas. (BNA) 1666 (E.D. Pa. Aug. 2, 2005). The plaintiffs in that case alleged, among other things, that the defendant pharmacy benefit managers (including PCS) improperly charged them higher co-payments than they should have been charged due to incorrect coding of generic drugs as brand drugs and improperly prevented them from obtaining mail order discounts. As the *Cooperstein* court explained in finding that *Aetna* mandated preemption: "Plaintiffs essentially ask the Court to recover benefits withheld by Defendants and to enforce parts of their ERISA plan." *Id.* at 1673. That is

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[4] *E.g., Plumbing Indus. Bd., Plumbing Local Union No. 1 v. E.W. Howell Co., Inc.*, 126 F.3d 61, 69 (2d Cir. 1997) ("A suit need not be a cognizable, winning claim under § 502(a) in order to fall 'within the scope' of the provision for purposes of [jurisdictional] analysis.").

precisely what the petitioners seek here in asserting that they were deprived of the benefit of the plans' generic drug co-payment rate. Pet. App. 10-11.

Petitioners argue (Pet. 9-11, 13) that there can be no ERISA preemption here because they "do not sue their plans' administrator or fiduciary." In *Aetna*, the named defendants were not ERISA plans, but rather were managed care entities (HMOs) that contracted with the employers to provide administrative services to the ERISA plans. *Aetna*, 542 U.S. at 210-14; *see also Pegram v. Herdrich*, 530 U.S. 211, 227 (2000) ("[t]he HMO is not the ERISA plan"). Nonetheless, it made no difference for preemption purposes whether the ERISA plans were named as defendants. Rather, the question was whether, but for its obligation to provide administrative services for the ERISA plan, the HMO would have no relationship with the plaintiffs.[5]

There is no conflict among the lower courts on this issue. "'All courts of appeals to have considered the issue have held that ERISA pre-emption may apply regardless of whether the defendant is a plan fiduciary.'" Pet. App. 6 (quoting *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1330 n.13 (5th Cir. 1992)). More recently in *Jones v. LMR International, Inc.*, 457 F.3d 1174 (11th Cir. 2006), the Eleventh Circuit found that ERISA preempted the plan participants' state law claims against Great West Life & Annuity Insurance Company ("Great West"), which "performed services for the plan, including claims

[5] *See Aetna*, 542 U.S. at 211 ("the only relationship Aetna had with Davila was its partial administration of Davila's employer's benefit plan."); *id.* ("the only connection between Calad and CIGNA is CIGNA's administration of portions of Calad's ERISA-regulated benefit plan").

processing." *Id.* 1176. The court reasoned that, although Great-West was not a plan fiduciary, the claims asserted against it "'affect relations'" between the principal ERISA entities and plaintiffs. *Id.* at 1180 (citation omitted). "These claims thus are preempted regardless of whether Great West is an ERISA entity." *Id.*

Petitioners contend (Pet. 9, 13-14) that they do not claim a denial of ERISA benefits and that "their respective plans had nothing to do with [PCS's] misclassification." As the Supreme Court of Georgia found, petitioners' right to obtain a drug by paying particular co-payment "is undeniably a plan benefit." Pet. App. 4. *See also Heffner v. Blue Cross & Blue Shield of Alabama, Inc.*, 443 F.3d 1330, 1338 (11th Cir. 2006) ("not having to pay a deductible is a benefit of a plan"). The plans at issue not only direct participants to submit claims for prescription drug benefits to AdvancePCS, but also specifically define "generic" drug for purposes of determining applicable co-payments. These plan definitions of a "generic" drug establish unequivocally that petitioners' state cause of action is *not* independent of the plans' terms. *See Del Greco,* 337 F. Supp. 2d at 489-98 (claims administrator's assessment of a "branded" co-payment for tamoxifen citrate was not arbitrary and capricious under the plan's terms). As the court below found, "[o]nly if the plan entitles them to a generic co-payment for tamoxifen would their unjust enrichment claims against PCS have any merit." Pet. App. 4.

II. The Decision Below Does Not Conflict With This Court's Earlier Decisions

Petitioners argue (Pet. 11-13) that the decision below is inconsistent with this Court's pre-*Aetna* decisions recognizing a presumption against preemption in areas of traditional state regulation. The cases petitioners cite are demonstrably inapposite. *See* Pet. 12 (*citing, e.g., New York*

State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997)). In those cases, the Court held that state statutes of broad general applicability were not preempted by ERISA because they had only a speculative and indirect effect on the costs of health care services offered under certain ERISA plans. *E.g.*, *Travelers*, 514 U.S. at 668. These cases did not address causes of action seeking enforcement of an ERISA benefit plan brought under state law. In this case, by contrast, petitioners' state-law tort claims (if proven) would directly affect the benefits actually available under that ERISA plan. Pet. App. 4, 10-11.

Petitioners appear to believe that, in *Travelers*, the Court overruled or at least drastically modified its prior holdings including in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983). Pet. 9. However, the Court was careful to avoid that implication, expressing in *Travelers* its "fidelity to the views expressed in our prior opinions on the matter." *Travelers*, 514 U.S. at 668 (*citing Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983)).

The cases petitioners cite bear no resemblance to this case. *Travelers* addressed a state law that required hospitals to collect surcharges from patients covered by commercial insurers, but not from patients covered by a Blue Cross & Blue Shield plan. This Court held that the state law did not "relate to" ERISA plans within the meaning of § 514(a) because it did not require plan administrators to purchase any particular health insurance package. 514 U.S. at 659-60. The surcharge had merely an indirect economic effect on the relative costs of the various insurance packages available for purchase by plans, *id.*, which the Court described as "a far

cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* at 662.

Dillingham involved a statutory exception to the state's general wage law that permitted a public works contractor to pay workers in a state-approved apprenticeship program less than the prevailing wage. The Court described the effect of this statute as "substantially similar" to that of the surcharge program in *Travelers*. 519 U.S. at 334. It merely encouraged apprenticeship programs to meet the state's standards for approval, without requiring them to do so. *Id.* at 332-33; *see also id.* at 334 ("The prevailing wage statute alters the incentives, but does not dictate the choices, facing ERISA plans."). Thus, as in *Travelers*, the Court held that the statute did not "relate to" ERISA plans within the meaning of § 514(a). 519 U.S. at 334.

The issue in *De Buono* was whether ERISA preempted a state gross receipts tax on hospitals when applied to hospitals owned and operated by an ERISA plan. The Court found that the economic impact of this statute was no different than the surcharge program in *Travelers* — if the ERISA plan had chosen to purchase health care services from an independently run hospital, that hospital would have passed the expense of the gross receipts tax onto the plan through the rates charged for its services. 520 U.S. at 816. It was thus indistinguishable from the "'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of [§ 514(a)]." *Id.* at 815.

This case is distinguishable from *Travelers*, *Dillingham* and *De Buono*. As the court below found, petitioners seek direct enforcement of the provisions of their ERISA benefit plans, not through ERISA's exclusive enforcement provisions, but through state causes of action. The terms of the plans are the deciding factor in determining PCS's liability. There is no independent federal or state right to

have a differential co-pay for generic or brand name drugs, much less an independent federal or state right to have a lower co-payment for tamoxifen. Petitioners' co-payment responsibility (whatever it may be) exists only because *the plans* required petitioners to pay a specified amount to the pharmacy before the plans became obligated to pay the remaining cost of the drug.

Moreover, it is the very objectives and policy considerations behind ERISA that require preemption here. This Court has consistently applied ERISA's preemption to state laws that risk subjecting plan fiduciaries and administrators to a patchwork of conflicting state regulation. "Requiring ERISA administrators to master the relevant laws of the 50 States and to contend with litigation would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators—burdens ultimately borne by the beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (alternations in original). In this litigation, petitioners bypassed the plans' ERISA-mandated internal appeal procedures that would have permitted the plan sponsors to interpret their respective plans. Petitioners instead sought to use state tort law to regulate the ERISA plans and entities. The plans at issue here are not unique; many plans outsource the initial processing of benefit claims to a third party whose decisions are subject to review by a plan fiduciary. Allowing petitioners to proceed on their state cause of action challenging PCS's initial co-payment assessments would undermine the exclusivity of ERISA's civil enforcement provision and expose ERISA plan fiduciaries, sponsors, and administrators in various states to different standards and conflicting state regulations. This type of activity is

prohibited by ERISA, and such prohibition is enforced by way of ERISA's preemption clause.[6]

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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October 23, 2006

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[6] The underlying benefit dispute in the case — whether tamoxifen is a generic or brand name drug — is now moot. PCS uses independent sources to classify tamoxifen. (Pet. App. 10). Those sources classified tamoxifen as a brand name drug during the time period at issue in the complaint because, due to patent restrictions on the drug, there were no generic manufacturers in the market. The patent has since expired, however, and tamoxifen is now classified as a generic drug.